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**Abstract**

**Background:** Wellbeing is an important outcome in the context of recovery from mental illness. The views of mental health professionals on wellbeing may influence their approach to supporting recovery.

**Aims:** This study aims to explore views held by mental health staff about factors influencing their own wellbeing and that of service users with psychosis.

**Method:** Semi-structured interviews were conducted with 14 mental health staff in South London who had worked with people with psychosis. Thematic analysis was used to analyse the data and comparisons were made between staff views of wellbeing for themselves and service users.

**Results:** Staff participants held similar conceptualisations of wellbeing for themselves and for service users. However, they suggested a differential impact on wellbeing for a number of factors, such as balance, goals and achievement, and work. Staff employed a more deficit-based perspective on wellbeing for service users and a more strengths-based view for themselves.

**Conclusions:** Staff stated a recovery orientation in principle but struggled to focus on service user strengths in practice. A stronger emphasis in clinical practice on amplifying strengths to foster self-management is indicated, and staff may need support to achieve this emphasis, e.g. through specific interventions and involvement of peer support workers.

**Declaration of interest:** none

**Keywords:** wellbeing, psychosis, staff, recovery, qualitative

## Introduction

Wellbeing is important for healthy individuals as well as those with mental and physical health problems. The Foresight Report identified determinants of wellbeing (Foresight, 2008), and underpins population-level research on measuring and improving wellbeing (Beaumont, 2011). This has allowed national snapshots (Randall et al, 2014) and trans-national comparisons (Randall & Corp, 2014). Wellbeing has been investigated in depression (Wood & Joseph, 2010), schizophrenia (Smith et al., 2007) and mixed mental illnesses (Malcolm et al., 2013). However, the conceptual underpinning of wellbeing remains unclear, making comparability of study results problematic (Schrank et al., 2013).

Building on previous research defining wellbeing in mental health (Schrank et al, 2013a), a dynamic framework of wellbeing for psychosis has been developed (Schrank et al., 2013b). The dynamic framework links wellbeing with people's striving towards an enhanced, more positive, sense of self, and identifies four clusters of influences on this transition: observable (visible behaviours and characteristics); non-observable (internal emotional and cognitive processes); proximal (factors under partial individual control in the immediate physical and social environment); and distal (factors beyond individual influence, in the more distant environment). Factors influencing wellbeing overlap with factors influencing recovery (Leamy et al., 2011). However, wellbeing goes beyond recovery and can be considered an outcome of the recovery process (Trujols et al., 2013). Specifically wellbeing is relevant for individuals irrespective of their experience of mental illness.

Staff perspectives on fostering wellbeing are important. Self-awareness, for example, may help staff to more sensitively develop recovery oriented care plans in collaboration with service users (Meddings & Perkins, 2002), and improve the staff-patient relationship (Gómez & Aillach, 2013). The aim of this study was to compare views held by staff about factors that

influence their own wellbeing and factors that influence the wellbeing of service users with psychosis.

## Subjects and Methods

### *Sample*

This study was undertaken in the context of the larger WELLFOCUS Study to test an intervention to improve wellbeing for people with psychosis (Schrank et al, 2014). A convenience sample of mental health staff were recruited from six community mental health teams in London. The inclusion criterion was experience of clinical work with people with psychosis. We increased diversity by recruiting individuals from a range of professional backgrounds, with differing working experiences, gender and age. Recruitment was conducted with the goal of theoretical saturation, *i.e.* until additional interviews no longer led to the generation of additional categories (Willig, 2008). Topic guides initially focused on staff opinions on service user wellbeing, to support the development of a framework of wellbeing for people with psychosis (Schrank et al, 2013b). However, it immediately became clear that staff referred to their own wellbeing and that of service users separately. Hence, topic guides were adapted to explicitly explore the distinction between participants' own wellbeing and service user wellbeing in more depth. This was done assuming a realist position, that there is a reality independent of the researcher and that the aim of research is to produce accounts that correspond to that reality (Hammersley, 1992).

### *Procedures*

One researcher (BS) conducted all interviews between October and November 2011. The topic guide asked about participants' personal experience of wellbeing and its improvement, what they thought wellbeing meant for service users with psychosis, and how service users could improve their wellbeing. Interviews lasted 30-90 minutes. All interviews were audio recorded, transcribed and anonymised.

### *Analysis*

We undertook a thematic analysis of the data using a combination of deductive and inductive techniques (Braun & Clarke, 2006). First, all data were deductively coded using a pre-defined coding framework developed in a previous study exploring wellbeing with service user participants with psychosis (Schrank et al., 2013b). According to this framework, wellbeing is defined as an ongoing individual process in which the current sense of self undergoes a transition towards an enhanced more positive sense of self. In the present study the coding framework was applied in two separate contexts: 'staff-on-self', where staff discussed their own wellbeing, and 'staff-on-service-users' where they discussed the wellbeing of service users. The framework was originally formulated to investigate wellbeing in people with psychosis. However, due to the breadth of its scope it was considered sufficiently general to be applied as a starting point in this study to explore staff views of wellbeing. Views of wellbeing not fitting into the original framework were inductively coded into new emergent categories using constant comparison (Braun & Clarke, 2006). In a second step, the coding frame was adapted to fit the current data including a process of interpretative coding, and all data re-coded in the final coding frame (Willig, 2008).

Second, the two staff accounts of wellbeing (staff-on-self and staff-on-service-users) were compared to identify differences in content and in explicit or implicit values and importance attached to contents. This process entailed interpretative coding. Seven raters from different backgrounds and with differing pre-existing familiarity with the topic independently coded all or proportions of the transcripts. The analysis was regularly discussed amongst the research team, with consensus reached on alternative codings and interpretations, and emerging results adapted in an iterative process. Transcripts were analysed using NVivo 9.

## Results

Fourteen participants (seven occupational therapists, four clinical psychologists, two social workers, one psychiatrist) were interviewed: ten females (71%), mean age 36.5 years (SD 10.3), mean length of work experience 11.6 years (SD 12.4).

Participants expressed the view that there were no general differences in what wellbeing means for themselves as distinct from service users. Participants often explicitly referred to a recovery oriented service model and an assumption of equality of all individuals. Whilst referring to the same general components as relevant for improving wellbeing for both themselves and service users, participants went on to describe differences in the impact of each of these components on the wellbeing of each group.

Participants introduced three additional components contributing to wellbeing, which were added to the coding framework: age, balance and achievement. The final coding framework, applied separately to staff-on-self data and staff-on-service-user data, is shown in Figure 1.

*Insert Figure 1 here*

Staff views on improving their own versus service users' wellbeing is now compared.

***Mental and physical health***

Participants regarded mental health as the key factor influencing service users' wellbeing. In respect of their own wellbeing, they did not refer to illness but only to minor distress and changes in mood, *e.g.* due to life events or a lack of work-life balance. Participants described the severity of symptoms, together with the level of understanding service users had about their illness, as decisive for improving wellbeing.

> *"if people don't understand their condition they don't understand the limitations that are imposed on them. By understanding their condition, they can gain a sense of empowerment."* [#13]

Overall, participants remained divided about whether a total alleviation of symptoms was necessary for service users to achieve a good level of wellbeing or if symptom reduction or the ability to manage symptoms as a more realistic goal would suffice.

Participants assumed important barriers to improving wellbeing were particularly related to mental illness and hence important for service users. But they made no such reference for themselves. These barriers specifically included stigma and discrimination, and greater difficulties with interpersonal relationships.

> *"They've got psychosis but a lot of other things go with it as well, around stigma and discrimination and things."* [#5]

***Activities***

Participants suggested that improving wellbeing for service users was more about "*managing day to day activities*" [#13] or "*living independently*" [#14], while they talked about increasing their own wellbeing by pursuing leisure activities and developing career goals for themselves. They also considered engaging in activities to be an important influence on wellbeing. For themselves, participants emphasised activities they enjoyed, while they thought service users needed to be encouraged to do *"meaningful activities"* [#11] and things "*of value*" [#12], not just activities for the sake of having something to do.

The assumption was evident that choosing valuable activities was more difficult for service users, while staff knew their own values and preferences and naturally sought out corresponding activities. Participants also felt there may be fewer opportunities to do things of value for service users, due to internal constraints with respect to socialising, motivation or self-reflection, and external constraints such as money or available opportunities.

> "*feeling that you have the opportunity to do what you may want to do but also knowing what you want to do*" [#3].

Participants emphasised their career, job or occupation as a key activity. They acknowledged that work may have a positive influence also on service users' wellbeing and thought that many service users wanted to get into work in some capacity. However they assumed less demanding activities than paid employment to be more appropriate for service users.

***Goals and plans for the future***

Participants felt that they had realistic goals, plans and aims for the future which provided them with a sense of purpose and direction. In contrast, they assumed that service users' wellbeing was impeded by their trouble planning for the future. Staff thought service users needed to be more realistic with respect to their goals and that many service users wrongfully expected a life completely without stressors or problems in order to have a good level of wellbeing.

> "*their sense of wellbeing is a bit too much about perfection, like no sadness at all or no stress.*" [#3]

***Relationships***

Participants considered relationships with friends and family immensely important for the wellbeing of both themselves and service users, but the nature of relationships and the associated challenges were considered to differ between the two groups.

> "….*one of the things that psychosis affects in people is how they relate to other people… Many ….have very few friends and actually find relationships quite difficult."* [#6]

Participants referred to themselves as usually having a sufficient number of satisfying relationships. By contrast, they characterised service users as more socially isolated and challenged by the goal of gaining and maintaining relationships.

***Sense of meaning***

Overall, participants described people's sense of self, their identity, as closely linked to having a sense of purpose and meaning in life. They described this identity-establishing sense of meaning as central to wellbeing and identified it as a major problem area for service users due to their illness experience.

> "*A lot of people feel that that they've come to this service not really knowing maybe who they are post-illness or that that's been really trampled, so working with people a lot to build up their identity*" [#9]

Participants did not explicitly refer to sense of self to as being a key indicator of wellbeing for themselves. However, it arguably was inferred through the importance participants placed on their careers for defining their place in society and how they feel about themselves.

Participants deemed having a sense of meaning, purpose, and a role in society and in a smaller family unit as important elements of wellbeing for both themselves and service users.

> "*I do think a lot of the clients with psychosis don't feel that they have a role at all, they understand that they are someone's son or daughter but maybe not feel that it is a role in itself*." [#3]

Participants felt they already had a sense of purpose by virtue of their occupation, but thought that this may not be the case for service users. Staff also implied that service users should aim for purposeful roles that are smaller.

***Age***

Participants introduced age, or the passage of time, as a new factor influencing wellbeing. They considered age to be important for wellbeing both for themselves and service users, affecting a person's values, interests, relationships and goals.

> *"…as I get older, I feel like I have a much better sense of myself than I did. You perhaps tap into qualities you didn't know you had…*." [#8]

Further, participants described age as having a differential impact on people depending on whether they had an illness or not, distinguishing themselves from service users.

> "*Having a long term illness is affecting how you think about the future. Someone who's younger and hasn't had it for so long may be not feeling negative about the long term effects. Their ideas of wellbeing might be pretty similar to me, things like friends, career, education. Whereas someone who has had it for 10-20 years….they're not so focused on achieving long terms goals but just think more about the present*." [#14]

***Achievement***

Participants also cited achievement as a key influence on wellbeing, but reflected that a key difference was evident in the meaning of achievement in the context of wellbeing for themselves and service users. Participants linked their own generally satisfactory level of wellbeing to having achieved attributes commonly valued by society as being favourable, especially occupation and career. By contrast staff expected service users to infer a subjective sense of achievement from small, everyday things which may carry less external validation.

> *"I think if incrementally you can start with small things, recognise the small goals with people and get them to feel good"* [#1]

***Balance***

Participants introduced balance as a new aspect, integral to wellbeing. Many said that for them, balance was represented by "*having a good work / life balance" [#10].* However, participants assumed that for service users balance was more about ensuring time spent alone was offset by sufficient time with others, to minimise loneliness. Participants also referred to balance in relation to emotions and maintaining stability, which again they considered easier for themselves than for service users.

## Discussion

Participants generally expressed a view that the same factors were relevant for improving wellbeing, but they described differences in the way they thought these affected their own wellbeing as opposed to the wellbeing of service users. Overall, participants retained a consistent focus on mental illness and its consequences as the main factor differentiating between their own and service users' wellbeing. This pathologising characterisation of service user wellbeing gave an impression of at times pronounced contrast, despite the intentionally adopted focus on commonalities within an explicitly assumed recovery orientation in their work. Participants did not claim immunity against deficit for themselves but implicitly referred to themselves as "healthy" throughout. Three new aspects of wellbeing – age, balance and achievement – were identified, which had not been captured in previous concepts of wellbeing for people with psychosis (Schrank et al., 2013a; Schrank et al., 2013b).

For themselves, participants associated getting older with gaining wisdom and perspective, whereas for service users, staff associated getting older with service users accepting their illness and corresponding changes in empowerment, lowering expectations and adjusting to a chronic disorder. The feeling of having a purpose in life, considered an important indicator of wellbeing by participants in the present study, has been found to decrease over the course of psychotic illness (Turner et al., 2007). Despite the conflation of concepts of meaning and identity by participants, which is not supported by wider literature, practical implications may be inferred from it especially in connection with age. A corresponding clinical implication is the recommendation to view older service users as having more insight and experience at managing demands in life, as opposed to lower expectations. More strengths-based, rather than deficits-based approaches, are indicated for clinical assessment and care planning (Bird et al., 2012).

Participants perceived balance in life as indicative of a state of wellbeing, but the context for understanding balance differed when applied by staff to themselves as opposed to service users. For the staff participants themselves, balance had a connotation of work / life balance, whilst for service users it referred to balancing out those areas of life that are impaired by illness, such as mood and relationships. In other words, balance for staff tended to relate to positive socially valorised roles, but for service users the focus was more on ameliorating the impact of negative influences. However, the concept of balance may have many connotations in relation to seeking to improve wellbeing, as reflected in non-western cultures. This differentiation is similar for example to how the First Nations and Inuit communities in Canada define mental wellness as "*a lifelong journey to achieve wellness and balance of body, mind and spirit*" (Mental Health Working Group, 2002) (p.1). The implications of a greater focus on supporting balance warrant further investigation.

Differences were also present in the contribution of goals and expectations to wellbeing. The goals participants had for themselves were more ambitious than goals they suggested service users may sensibly be encouraged to pursue; a theme which is illustrated by past research (Davidson & Johnson, 2013). Whilst this may reflect a clinically beneficial position supporting people to avoid disappointment by ensuring goals are appropriate, it may also be detrimental to developing a sense of empowerment and confidence for service users. Individuals may benefit from taking responsibility for setting their own recovery goals, rather than aiming for goals set by professionals, even if the latter may be more realistic (Davidson et al., 2009). In clinical practice, low expectation and therapeutic pessimism may be unhelpful both for service users and for staff themselves (Horowitz, 2008).

Overall, participants perceived service users as challenged and disadvantaged. Although consistent with research (Häfner & Heide, 1997), this may indicate the struggle to retain hope which is known to be important to support recovery (Schön & Rosenberg, 2013). The ambivalence about whether full symptomatic recovery is necessary may reflect limited

understanding of current conceptualisations of recovery, either specifically in psychosis (Law & Morrison, 2014) or its wider societal implications (Henwood & Whitley, 2013). There was no reference to scientific research on wellbeing, either at the population level (Ryff, 2014) or specifically in relation to psychosis (Mankiewicz et al, 2013).

### *Strengths and Limitations*

This study is the first to compare the views of mental health professionals on what affects their own well-being and how this differs from what affects service users' wellbeing. A limitation is that staff tended to emphasise and refer to service users at an early stage of recovery or struggling with recovery for a relatively large amount of time. This may have increased the focus on lower functioning levels in service users. It cannot be assumed that the findings represent those of all staff generally. This study also did not include data collected from service users, limiting generalisability. The analysis used a coding frame derived from a previous study which explored the meaning of wellbeing in a sample of service users with psychosis.

### *Conclusions*

This study suggests four key conclusions. First, similarities in how staff report perceiving wellbeing for themselves as individuals and for service users suggests they have embraced recovery-orientation in principle. Recovery often includes a shift in power relations towards a more equal partnership (Le Boutillier et al., 2011). Whilst only reflective of staff views, our findings may reflect the movement towards such an equal partnership. Future research may focus on the views of service users about wellbeing, to provide a greater insight into such a power shift.

Second, an alternative interpretation of the results is that staff only superficially espouse a recovery framework. This is supported by the fact that staff referred to differences in more detail while similarities were described at a more abstract level and with differing examples

for the two groups. This interpretation supports the critique that 'recovery' services represent a nominal re-badging of mainstream services with substantive change. Ethnographic research using participant observation of both formal and informal talk would be necessary to investigate this possibility.

Third, differences in staff perceptions of wellbeing were present specifically in relation to expectations. If wellbeing is indeed different for service users, then this difference may be appropriate where a service user has fewer resources or other disadvantages. If by contrast the reported differences are due to stigmatising staff beliefs, then this may inadvertently hinder the development of wellbeing by creating a culture of low expectations leading to widespread under-achieving. The clinical implication is that staff take a more person-centred approach to expectations for service users with psychosis, rather than making assumptions based on training and pessimistic clinical experience.

Fourth, results indicate that staff may struggle to notice and activate service users' strengths. This suggests the usefulness of a more systematic approach to strengths as a routine part of clinical care (Bird et al., 2012). The developing involvement of peer support specialists, *i.e.* people with personal experience of mental illness and recovery, may support such a strengths-based approach (Repper & Carter, 2011). Overall, slow and incremental progress towards a realistic view of staff-service user similarities and differences is underway.

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**Figure 1: Final coding framework for influences on wellbeing**

- **1. Health**
  - Mental health
    - Symptoms and medication side effects
    - Stigma and discrimination
    - Coping with symptoms and illness consequences
    - Mental health service use and support-seeking
  - Physical health
    - Somatic illness
    - Lifestyle and physical self-care
- **2. Activities**
  - Work and voluntary work
  - Leisure activities
  - Activities of daily living
  - Trying new things
- **3. Goals and plans for the future**
  - Aspirations
  - Dreams and desires
- **4. Relationships (Social interaction and problems therewith)**
  - Family, children
  - Friends, colleagues
  - Intimate partners
  - Service providers
- **5. Meaning and identity**
  - Focus in life
  - Meaningful and valued role
  - Sense of purpose
  - Orientation, meaningful reference system
- **6. Age**
  - Reflection
  - Coming to terms, reality reference
  - Changing values, attitudes, goals
- **7. Achievement**
- **8. Balance**
  - Psychological and spiritual self-care